TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 9, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447.253	7. FEDERAL BUDGET IMPACT: a. FFY 1996-1997 $ 0 b. FFY 1997-1998 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Part II Pages 1,2,6,7 *** SEE REMARKS	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A Part II Pages 1,2,6,7

10. SUBJECT OF AMENDMENT:

Disproportionate Share Payments to OMH Facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Barbara A. DeBuono	16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237
13. TYPED NAME: Barbara A. DeBuono, M.D., M.P.H.	
14. TITLE: Commissioner	
15. DATE SUBMITTED: June 30, 1997	

17. DATE RECEIVED: [redacted]

19. EFFECTIVE DATE OF APPROVED MATERIAL: [redacted]

21. TYPED NAME: [redacted]

23. REMARKS: [redacted]

FORM HCFA-179 (07-92)

Instructions on Back

[redacted]

METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR INPATIENT SERVICES PROVIDED BY HOSPITALS OPERATED BY THE NEW YORK STATE OFFICE OF MENTAL HEALTH

In accordance with the Mental Hygiene Law the Office of Mental Health (OMH) establishes Medicaid inpatient rates of reimbursement, subject to the approval of the Director of the State Division of the Budget, for the psychiatric hospitals it operates.

I. GENERAL

A separate rate is established for each of the following classifications of facilities:

(1) Psychiatric Centers

This rate category includes all inpatient units located at OMH Medicare and Medicaid certified Psychiatric Centers with the exception of Forensic Psychiatric Centers for which a separate rate category is established.

(2) Children's Psychiatric Centers

This rate category applies to those separate and distinct Children's Psychiatric Centers ("CPCs") operated by the OMH. The CPC's provide psychiatric care and treatment exclusively to children and adolescents.

(3) Forensic Psychiatric Centers

This rate category applies to those separate and distinct inpatient facilities that provide a highly secure treatment environment for patients who are too dangerous to be treated in regular State psychiatric centers.

Medicaid inpatient rates for each rate category are established prospectively on a statewide basis by averaging together each of the per diem rate components outlined below for all Medicaid certified facilities.

II. BASE YEAR OPERATING PER DIEM

The operating per diem of the inpatient Medicaid rates is developed by averaging together the following:

A. For Medicare Certified Psychiatric Centers (including Forensic Psychiatric Centers)

The Medicare (Title XVIII) per diem payment rates

resulting from the final settlement of OMH's Medicare cost reports covering fiscal year ended March 31, 1991. Medicare final settlements are issued by OMH's Medicare Fiscal Intermediary following their review and audit of the Medicare cost reports submitted by OMH for each of the Medicare participating providers it operates. For purposes of Medicare reimbursement OMH Psychiatric Hospitals are treated as PPS exempt providers with payment rates developed in accordance with 42 CFR section 413.40.

B. For Childrens Psychiatric Centers

Since the Childrens Psychiatric Centers are not Medicare participating providers, the base inpatient per diem for these facilities shall be determined based on their average inpatient cost per day for the base year. The base year to be utilized shall be the same fiscal year as that used for the Medicare participating psychiatric centers as outlined under paragraph II.A. above.

The inpatient cost per day for the Childrens Psychiatric Centers shall be determined in accordance with the cost reporting and costfinding methods developed by the Hospital industry as adopted by the Medicare (Title XVIII) and Medicaid (Title XIX) Programs. In determining those items of cost that shall be determined to be allowable, Medicaid (Title XIX) laws, rules and regulations shall be applied in accordance with paragraph III.A. below.

C. Exclusion of Capital Cost

In developing the statewide average base year operating per diem for each rate category, capital costs shall be eliminated from the amounts included in the per diems described above under paragraphs II.A. and II.B. For purposes of this section capital costs shall be determined in accordance with the Medicare (Title XVIII) principles of reimbursement and accordingly will include depreciation on

IX. DISPROPORTIONATE SHARE ADJUSTMENT

The Medicaid payment rates for OMH facilities will be adjusted in accordance with Sections 1902 (a)(13)(A) and 1923 of the Social Security Act to account for the situation of OMH facilities which serve a disproportionate number of low income patients with special needs. The adjustment will be made if either the Medicaid inpatient utilization rate for OMH hospitals is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or if the low income utilization rate for OMH hospitals exceeds 25 percent.

The Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days in a cost reporting period divided by the total number of the hospitals inpatient days in that same period.

The low income utilization rate is defined as the sum (expressed as a percentage)of the fraction calculated as follows:

- Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,
- The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period less the portion of cash subsidies reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient service in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

Those OMH hospitals that qualify as a disproportionate share hospital will receive a payment adjustment to fully reimburse the hospital for the unreimbursed costs incurred in providing services to individuals who are either eligible for medical assistance or who have no health insurance or other source of third party coverage for the services provided.

X. DISPROPORTIONATE SHARE LIMITATIONS

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, 1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient days shall not be eligible to receive disproportionate share distributions.

Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OMH facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor's certification that the hospital's applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating that all distributions in excess of the 100 percent limit will be used for health services.

No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act, other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patient made by the State of a unit of local government within the State shall not be considered a source of third party payment.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered a "high DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospital receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period.

Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient cost shall be made upon receipt of an appropriate report.

Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has be compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceeded the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payment are due the facility, such additional payments will be made.

XI. TRANSFER OF OWNERSHIP

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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